State of California Health and Welfare Agency

ANNUAL UTILIZATION REPORT - 1997

Long Term Care Facility

STATE USE ONLY

Page 0, Line 1

LICENSE
STATUS 3 ____ TYPE 6 ____

Return **BY FEBRUARY 15, 1998** to:
Office of Statewide Health Planning
and Development
Licensed Services Data Section
818 K Street, Rm. 500
Sacramento, CA 95814

Completion of the "Annual Utilization Report of Long Term Care" is required by Section 127285 of the Health and Safety Code, and is a requirement for the licensure of your health facility. Failure to complete and file this report by February 15, may result in action against the facility's license.

If you have any questions please contact the LTC analyst at (916) 322-7422.

"I declare the following under penalty of perjury: that I am the current administrator of this facility, duly authorized by the governing body to act in an executive capacity; that I am familiar with the record keeping systems of this facility and the records and logs are true and correct to the best of my information and belief; that I have read this annual report and am thoroughly familiar with its contents; and that its contents represent an accurate and complete summarization from our medical records and logs of the information requested."

_____
Administrator's Name (Please Print)

_____
Name of person completing form and /or contact person for any follow-up questions (Please Print)

_____
Administrator's Signature

_____
Print Title and Department of Person Responsible for the Report

_____
Date

( ) _____
Area Code Phone Ext.

3. ( ) _____
Area Code Facility Phone Number

( ) _____
Area Code FAX Number

COMPLETE THIS PAGE ONLY IF THE FACILITY HAS CLOSED, WENT INTO SUSPENSE, NEWLY OPENED OR CHANGED LICENSEE/OWNERSHIP IN 1997.

A. DATES OF LICENSURE: If the facility was licensed on 1/1 or after or was delicensed (closed) or went into suspense on 12/31 or before, enter the dates of operation on Line 1, Columns 1 and 2. Month = 01 through 12 and Day = 01 through 31.

		Col. 1			Col. 2		
1.	FROM	Month	Day	THROUGH	Month	Day	

B. LICENSEE (OWNERSHIP) TYPE:

From the list below, select the ONE category that best describes the type of ownership (licensee) of your facility and enter the number which appears next to that category. ..... 2. ____

LICENSEE (OWNERSHIP) CODES		
NONPROFIT	**FOR PROFIT**	**STATE/LOCAL GOVERNMENT**
20 Church Related	23 For Profit, Whether:	11 State
21 Nonprofit Corporation	-Partnership	12 County: County or City or Hospital District
22 Other _____	-Corporation	
	-Individually Owned for Profit	

A. HOSPICE PROGRAM

Enter the number 1 if the facility offered a hospice program during the calendar year?.....1 ____
(A hospice is a centrally administered program of palliative and supportive services which provide physical, psychological, social and spiritual care for dying persons and their families, focusing on pain and symptom control for the patient. Care is available by a coordinated interdisciplinary team seven days a week, 24 hours a day and extends through the bereavement period.)

B. CERTIFICATION:

From the certification categories below, place a check on those categories for which your facility was certified or contracted during the year.

Medicare:	**Medi-Cal:**	**Medi-Cal:**	**Medi-Cal:**	**Medi-Cal**
Skilled Nursing	Skilled Nursing	Intermediate Care	Intermediate Care/DD	Subacute
Line 5 (Col. 1) ___	(Col. 2) ___	(Col. 3) ___	(Col. 4) ___	(Col. 5) ___

C. Length of Stay in Facility -- All patients discharged (See definition of "discharge" in instruction booklet)

TABLE A

Time in Facility	Line No.	Number of Patients
TOTAL DISCHARGES	11	*
Less than 2 weeks	12	
2 weeks less than 1 month	13	
1 month less than 3 months	14	
3 to 6 months	15	
7 to 12 months	16	
1 year less than 2	17	
2 years less than 3	18	
3 years less than 5	19	
5 years less than 7	20	
7 years less than 10	21	
10 years or more	22	

*Total discharges must be the same on page 4, line 3, column 6.

D. SPECIAL PROGRAMS

During the calendar year, what was the number of patients diagnosed as having AIDS, ARC, prodromal AIDS or HIV related disease and illness (HTLV-III/LAV)?.....41 _____

Enter the number 1 if your facility offered a specialized program for Alzheimer's patients?.....42 _____

During the calendar year, what was the number of patients who had a primary or secondary diagnosis of Alzheimer's Disease? .....43 _____

COMPLETE THE TABLE USING THE FOLLOWING:

(Line 1) + (Line 2) - (Line 3) = Line 4

The sum of line 2 (ADMISSIONS) columns 7-12 must equal the amount shown on line 2 column 6 (**Total**)

The sum of line 3 (DISCHARGES) columns 7-14 must equal the amount shown on line 3 column 6 (**Total**)

The sum of line 4 (CENSUS) columns 7-14 must equal the amount shown on line 4 column 6 (**Total**)

Line 2, Col. 7-12
Place Admitted From

Line 3, Col. 7-14
Place Discharged To

		SN (Gen)	IC (Gen)	SN (MD)	IC (DD)	Cong. Living	Total								
Dec. 31, 1996 Census	Ln. 1							**Home**	**Hospital**	**State Hospital**	**Other LTC**	**Residential Bd & Care**	**Other**		
(+) Admissions	Ln. 2													**AWOL**	**Death**
(-) Discharges	Ln. 3														
Dec. 31, 1997 Census	Ln. 4														
Patient Days	Ln. 5							**7 Medicare**	**8 Medi-Cal**	**9 HMO**	**10 Priv. Ins.**	**11 Priv. Pay**	**12**	**13**	**14 Other**
Licensed Beds	Ln. 6														
Licensed Bed Days	Ln. 7														
	Cols.	**1**	**2**	**3**	**4**	**5**	**6**								

Line 4, Col. 7-14 Reimbursement By Payer Source

Refer to Instruction Booklet

TABLE B

A. TOTAL NUMBER OF LTC PATIENTS

1. Number of Patients in the Facility on December 31 of the Reporting Year..... _____
2. Number of **Male** Patients on December 31 of the Reporting Year..... _____
3. Number of **Female** Patients on December 31 of the Reporting Year..... _____

B. RACE /ETHNICITY AND AGE OF MALE LTC PATIENTS ON DECEMBER 31.

Report These Patients by the Appropriate Age Groups:

	COL. 1 < 45	COL. 2 45-54	COL. 3 55-64	COL. 4 65-74	COL. 5 75-84	COL. 6 85-94	COL. 7 95 +
4. White	_____	_____	_____	_____	_____	_____	_____
5. Black	_____	_____	_____	_____	_____	_____	_____
6. Hispanic	_____	_____	_____	_____	_____	_____	_____
7. Asian	_____	_____	_____	_____	_____	_____	_____
8. Filipino	_____	_____	_____	_____	_____	_____	_____
9. Pac Islander	_____	_____	_____	_____	_____	_____	_____
10. Native Am	_____	_____	_____	_____	_____	_____	_____
11. Other	_____	_____	_____	_____	_____	_____	_____
12. Total	_____	_____	_____	_____	_____	_____	_____

C. RACE /ETHNICITY AND AGE OF FEMALE LTC PATIENTS ON DECEMBER 31.

Report These Patients by the Appropriate Age Groups:

	COL. 1 < 45	COL. 2 45-54	COL. 3 55-64	COL. 4 65-74	COL. 5 75-84	COL. 6 85-94	COL. 7 95 +
13. White	_____	_____	_____	_____	_____	_____	_____
14. Black	_____	_____	_____	_____	_____	_____	_____
15. Hispanic	_____	_____	_____	_____	_____	_____	_____
16. Asian	_____	_____	_____	_____	_____	_____	_____
17. Filipino	_____	_____	_____	_____	_____	_____	_____
18. Pac Islander	_____	_____	_____	_____	_____	_____	_____
19. Native Am	_____	_____	_____	_____	_____	_____	_____
20. Other	_____	_____	_____	_____	_____	_____	_____
21. Total	_____	_____	_____	_____	_____	_____	_____

A. SUBACUTE CARE PATIENTS

1. Total number of **Subacute Care Beds** contracted for on 12/31..... 1_____

	Col. 1 Age 20 and Under	Col. 2 Age 21 and Over
2. Number of Subacute Patients in the Facility on 12/31.	_____	_____
3. Number of Subacute Patients Admitted During the Year.	_____	_____
4. Number of Subacute Patients Discharged During the Year.	_____	_____
5. Number of Subacute Patient Days.	_____	_____

B. PLACE ***SUBACUTE*** PATIENTS REPORTED ON LINE 3 WERE ADMITTED FROM:

10.	Home	_____	_____
11.	State Hosp	_____	_____
12.	Residential Board and Care	_____	_____
13.	Hospital	_____	_____
14.	Other LTC	_____	_____
15.	Specified Other	_____	_____

C. PLACE ***SUBACUTE*** PATIENTS REPORTED ON LINE 4 WERE DISCHARGED TO:

20.	Home	_____	_____
21.	State Hosp	_____	_____
22.	Residential Board and Care	_____	_____
23.	Hospital	_____	_____
24.	Other LTC	_____	_____
25.	Specified Other	_____	_____
26.	Death	_____	_____

D. REPORT THE NUMBER OF ***SUBACUTE*** PATIENTS ON 12/31 THAT REQUIRED THE TREATMENT/PROCEDURES LISTED. (A patient may require more than one treatment/procedure:)

31.	Tracheostomy with Ventilator	_____	_____
32.	Tracheostomy without Ventilator	_____	_____
33.	Tube feeding (nasogastric or gastrostomy)	_____	_____
34.	Total Parenteral Nutrition (TPN)	_____	_____
35.	Physical Therapy	_____	_____
36.	Speech Therapy	_____	_____
37.	Occupational Therapy	_____	_____
38.	IV Therapy	_____	_____
39.	Wound Care	_____	_____
40.	Peritoneal Dialysis	_____	_____